

 **ACKNOWLEDGMENT OF REQUEST FOR RECORD RELEASE**

Patient Name

This letter is to confirm your call/visit to our office in which you requested copies of your radiographs to be released to

 We are happy to comply with your request. Under law, we are entitled to the reasonable cost of reproducing your records. In addition, we will need your written authorization for the record release.

Below, please complete, sign and date your request and return to us with your record fee. As soon as it is received, we will process your request.

Sincerely,

The office of Petrie, Storer & Associates, D.D.S

*I, ­­ , hereby request Petrie, Storer & Associates, D.D.S., to copy my recent radiographs on file at the office and send them to the above mentioned.*

*I have been informed there may be a cost of reproducing my radiographs;*

*Sincerely,*

*Patient (or Parent, if minor) Date*

**773.763.5353 | Fax 773.763.3565 7447 W. Talcott Ave., Ste. 560 Chicago, IL 60631 office@petriestorerdds.com**